

FOR PATIENT TO COMPLETE: Name: _____

Last 4 of SSN: _____

Symptoms currently:

1) Short of breath w/rest:

new; _____ better; _____
worse; _____ no change; _____
N/A _____

2) Short of breath w/daily activities:

new; _____ better; _____
worse; _____ no change; _____
N/A _____

3) Short of breath w/walking:

new; _____ better; _____
worse; _____ no change; _____
N/A _____

4) I can walk:

_____feet/yards/blocks/ miles
without stopping to rest

5) I stop to rest due to :

fatigue; _____ shortness of breath; _____
chestpain/pressure; _____
other _____

6) I wake up short of breath at night:

never: _____
1 to 3 times a month; _____
1 to 3 times a week ; _____
nightly _____

7) I sleep on :

one pillow; _____ two pillows; _____
three or more pillows; _____ upright _____

8) I wake up feeling rested in the morning:

never; _____ sometimes; _____
most of the time; _____
Always _____

9) I nap during the day:

never; _____ sometimes; _____
most days of the week; _____ everyday _____

10) I have chest pain, pressure, or heaviness:

with rest; _____ with activity; _____ with eating; _____
with stress; _____ I do not get chest pain _____

11) I get dizzy with standing:

never; _____ sometimes; _____
most of the time; _____
all of the time _____

12) I fatigue easily:

never; _____ sometimes; _____
most of the time; _____ all of the time _____

13) Weight at home/today _____

•Do you have a scale at home to weigh yourself? Yes/No •Do you have a Blood pressure cuff at home? Yes/No
•Do you need a medication fill box to assist you with managing your medications? Yes/No

Questions/Concerns I have today:

PATIENT NAME: _____ SS# _____

Physical Exam

Neck: JP _____ cm.

Cardiac: RRR; S1, S2; No GMR; _____

Lungs: CTA bilat; _____

Abd: Hepatomegaly; HJR

Extremities: no edema; +1 bilat LE edema; +2 bilat LE edema; +3 LE edema; +4 LE edema;

Heart Failure

with: _____ Preserved systolic function

_____ Systolic dysfunction

_____ Other

1) Volume status:

Overload _____

Euvolemic _____

Hypovolemic _____

2) NYHA Functional class: I, II, III, IV

3) At target doses of

ACE Inhibitor: (yes/no)

Beta blocker: (yes/no)

ARB: (yes/no)

4) Plan:

5) Follow-up: _____ Months / Weeks

6) Bloodwork: _____

7) Testing: echocardiogram; PFT's stress test; sleep apnea consult; LHC;RHC